59th Medical Wing

U.S. AIR FORCE

59 MDW Infectious Diseases Product Line Analysis Clinic Response

Information Brief

Briefer: Major Agan

Date: 21 Mar 2005

Overview

- 59 MDW/CC Follow-up Issues
  - Cleaning up existing data
  - MEPRS
  - Coding
- Basic CAMO Rules
  - Initial Clinic Business Rules
- Current/Future Problem Areas
- Support Requirements from 59 MDW/SA-MM

Cleaning Up Existing Data

Cleaning Up Existing Data

Discuss why visits dropped so much from FY03 to FY04

- Combination of:
  - Deployed personnel
    - Col Dolan (4 months), Dr. Agan (4 months)
  - Accidental “double-booking” of certain appointments by clerk was noted on audit and corrected
    - Expect to recapture this: what was being done was correct, how it was being done was incorrect
  - Decreased workload
    - Decrease in number of available beds → decrease in inpatients → decrease in consults → decrease in clinic follow-up visits

Cleaning Up Existing Data

Elevated walk-in:booked ratio

- Outpatient Clinic
  - No longer use “walk-in” for planned visits
  - These “planned walk-ins” now have a slot created and filled as EST$
    - Estimated to decrease our walk-in rate by at least 50%
    - Will measure this outcome in April ’05
- Inpatient Consults
  - Continue to use “walk-in” for first time consults
  - Start using EST$ for subsequent inpatient visits
  - Question: Why only 1 f/u visit allowed for inpatients?
    - RE: SGH Letter 15 Feb 05

MEPRS

MEPRS

Fix your MEPRS data if necessary

- ALL now understand MEPRS better
- Data that were not correct
  - 3 staff listed as fellows
  - 2 fellows listed as residents
  - 2 personnel not listed
  - Dr. Agan was still listed as deployed
  - 10 people to be removed from staffing list
    - 2 don’t work with us anymore
    - 8 contract personnel who do not belong on our MEPRS books

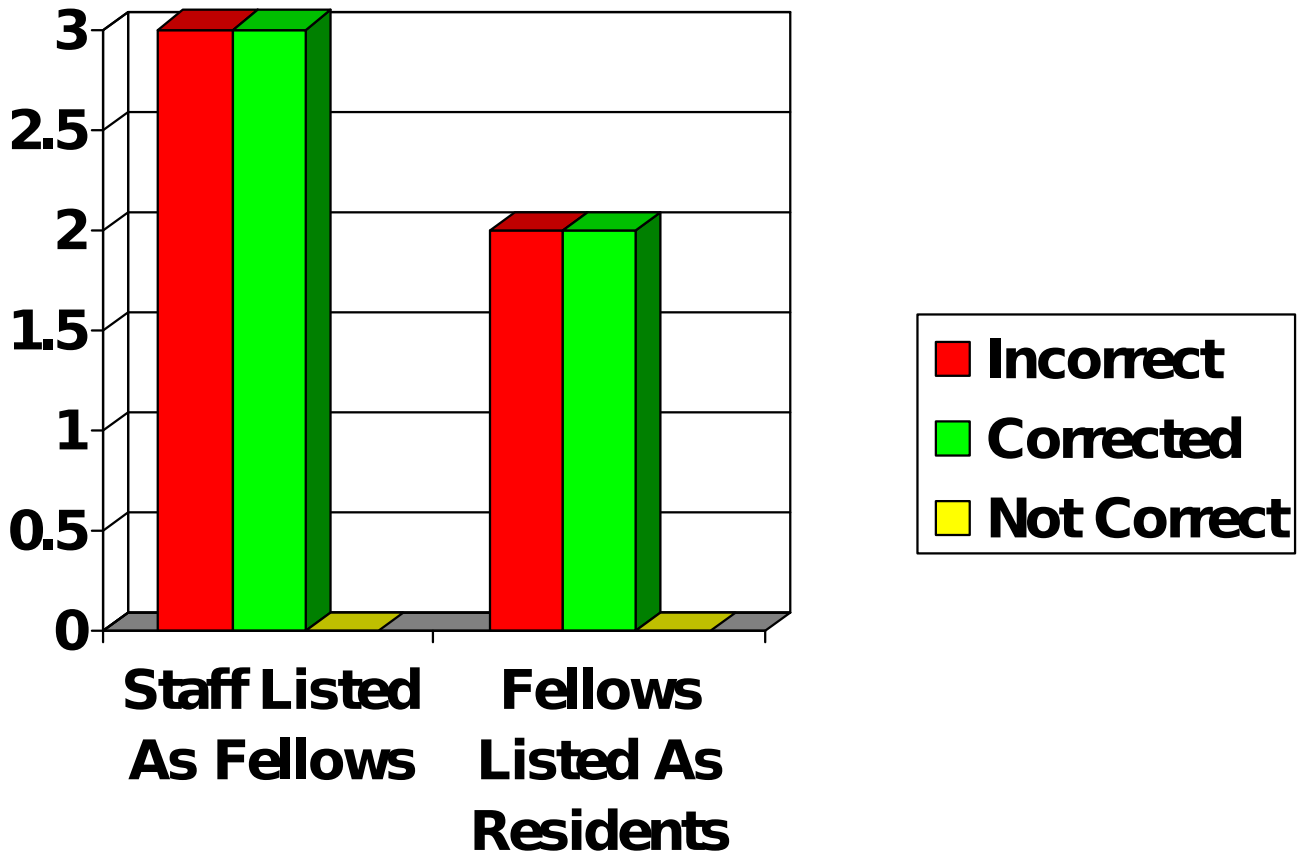
MEPRS

Fix your MEPRS data if necessary

- Corrective Action:
  - TSgt Schmitz met with Ms. Linda Goode and sent updated lists on who should be included in our MEPRS data with corrected job titles
  - Results have been mixed
    - Only have data from Dec ’04 to compare to Sep ‘04

MEPRS

Show "corrected" MEPRS information on a graph



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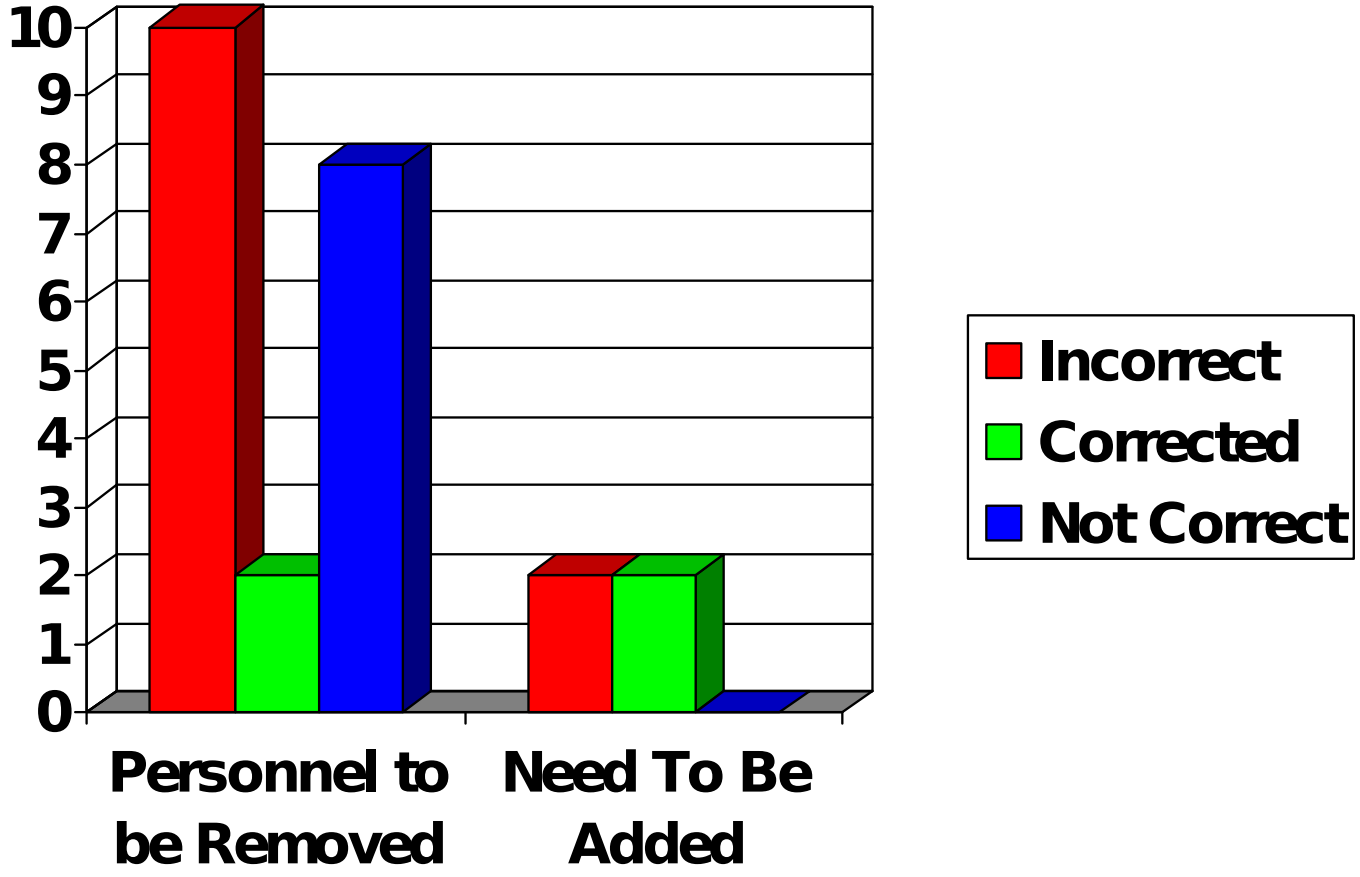

MEPRS

Show “corrected” MEPRS information

- What is not corrected?
  - Still need to remove 8 contract personnel that do not belong to our MEPRS
    - We have re-requested this action
  - Dec ’04 MEPRS hours reported are identical for all personnel except two
    - Dr. Agan no longer listed as deployed
  - New process began in January ‘05
    - Will re-assess monthly as data becomes available

MEPRS

Indicate steps to ensure MEPRS templates will be corrected/monitored for accuracy in the future

- Reviewed MEPRS rules and applications at MMII staff meeting 13 Jan 05
  - Emphasized accuracy in reporting, particularly regarding time in clinic and time on inpatient wards
  - Discussed proper use of codes for our activity
    - e.g. Grad Med Ed Supt vs. Ed Trng Pgm
  - Updated our MEPRS worksheet to reflect codes we use regularly
  - Discussed ways to accurately reflect our workload

MEPRS

Indicate steps to ensure MEPRS templates will be corrected/monitored for accuracy in the future

- Streamlined and improved MEPRS reporting
  - TSgt Schmitz created individual MEPRS folders
    - Includes present month's worksheet + all previous MEPRS sheets for comparison
  - Standardized collection times
    - Distributed on the 20th of every month
    - Due by the 25th of every month
    - Now know these are due to MEPRS input technicians by the 3rd of the month or else the previous month's data is repeated
  - Repercussions for failure to complete data
    - Must turn in prior to going TDY or Leave

Coding

Coding

Review areas of improvement with coding

- Met with our coder and our auditor
- ICD9 accuracy rate of 71.1%
  - Major problem: HIV/AIDS coded incorrectly
    - ICD9 codes not congruent with “medical speak”
    - Jan ’05 MMII Staff Meeting: discussed ways in which we can document accurately using correct medical terminology and simultaneously help coder determine proper code
  - Secondary problem: heavy use of “ODRI”
    - New medical term/abbreviation – coder was not familiar
    - Discussed writing this out and reviewed with coder
    - Coder given Dr. Conger’s # and pager for questions
    - Will petition for this to become “acceptable” abbreviation through proper channels

Coding

Review areas of improvement with coding

- Met with our coder and our auditor
- CPT accuracy rate of 50%
  - Largely result of not coding for procedures we perform regularly
    - Blood draws are performed daily
    - Testosterone, immune globulin and other injections
    - Placement of PPD’s
  - Discussed proper way to document and allow for proper coding of these and any other procedures we perform

Coding

Review areas of improvement with coding

- Met with our coder and our auditor
- E&M accuracy rate of 90.9%
  - Good results thanks to our coder
  - Leading cause of non-compliance: incorrectly identifying patients as “new”
  - At MMII Meeting:
    - Reviewed criteria for “new” patient
      - Not seen by clinic or inpatient consult service for 3 years
    - Reviewed need to document all aspects of history and physical to continue good performance in this area

Coding

Review areas of improvement with coding

- Began using professional coder to code all visits
  - Some previously coded by clinic staff
    - HIV Unit semi-annual patient visits
    - Inpatient Consults initial and follow-up visits
- Should more accurately capture and reflect our workload
- Provides consistency in our coding for all points of service
  - ID Clinic, Travel Clinic, HIV Unit, Inpatient Consults
- Exploring use of home health mgmt codes

Coding

Ensure your staff are getting credit for residents' workload for business plan purposes if not for third party billing

- Discovered ability to label staff as the "supervisor" for scheduled appointments at time appointment is made
- All fellow patient encounters now have default supervisor
  - If another supervises, both TSgt Schmitz and the coder have the ability to correct based on which staff signs and stamps the chart
- Created stamps with appropriate supervision language for staff to use on inpatient consults

Coding

Super Bill

- Updated existing super bill
  - Brought all HIV codes together with explanations
  - Added orthopedic device related infection code
  - Eliminated seldom used codes
  - Ordered 2005 code book and will double-check codes for accuracy since they do change
- Provides educational tool for our physicians and nurses to know how to document diseases in proper language for proper codes
- Communication tool between the coder and provider

Old Superbill

Viral Infections

042 HIV
075 EBV
053.9 HSV
079.6 RSV
078.5 CMV
052.9 VZV
079.51 HTLV-I
079.52 HTLV-II
079.99 Nonspec HTLV
487.1 Influenza
079 Nonspec Adenovirus

Skin Infections

682.9 Nonspec Cellulitis
SPECIFY SITE
680.9 Nonspec Carbuncle
729.4 Fasciitis
035 Erysipelas

Osteomyelitis

730.0 Acute
730.1 Chronic
MUST SPECIFY SITE

009.2 Nonspec Infect. Diarrhea
787.91 Diarrhea

Fungal Infections

110.1 Onychomycosis
112.0 Thrush
117.9 Nonspec Fungal
116.0 Blastomycosis
115.90 Nonspec Histoplasmosis
114.9 Nonspec Coccidioidomycosis
117.5 Cryptococcosis

Meningitis

322.9 Meningitis
320.9 Nonspec bacterial
SPECIFY ORGANISM
049.9 Nonspec Viral Encephalitis
SPECIFY ORGANISM
117.5 Cryptococcal
117.9 Fungal
047.9 Mollaret's

New Superbill

HIV
V08 HIV-HIV +, No Sxs
042 HIV-HIV+,Sxs,Tx, AIDS
V65.44 HIV-Counseling
V01.79 HIV-exposure to HIV
795.71 HIV-Nonspecific serologic evidence
263.9 Malnutrition

Other Viral Infection
075 EBV
053.9 HSV
079.6 RSV
078.5 CMV
052.9 VZV
079.51 HTLV-I
079.52 HTLV-II
079.99 Nonspec HTLV
487.1 Influenza
079 Nonspec Adenovirus

Osteomyelitis/Device Inf
730.0 Acute osteo*
730.1 Chronic osteo*
996.67/730.0 Acute osteo w/ODRI*
996.67/730.1 Chronic osteo w/ ODRI *
MUST SPECIFY SITE

Liver Diseases
070.9 Viral Hepatitis
570 Acute Hepatitis
571.40 Chronic Hepatitis
070.1 Hep A
070.30 Hep B
070.51 Hep C
070.52 Hep D
070.53 Hep E

Gastroenteritis
009.0 Infectious
008.8 Viral Enteritis
003.9 Salmonella
009.2 Nonspec Infect. Diarrhea
787.91 Diarrhea

Fungal Infections
110.1 Onychomycosis
112.0 Thrush
117.9 Nonspec Fungal
116.0 Blastomycosis
115.90 Nonspec Histoplasmosis
114.9 Nonspec Coccidioidomycosis
117.5 Cryptococcosis

Arthritis

Superbill

OLD **VS.** **NEW**

Procedures

87999 Cultures Unlisted (Blood/Wound)
90782 Drug Admin (SC/IM)
93000 EKG
51700 Irrigation
62270 Lumbar Puncture
32000 Thoracentesis
49080 Paracentesis
36000 Periperal IV
94760 Pulse Oximetry
99000 Specimen Handling

Procedures

87999 Cultures Unlisted (Blood/Wound)
90782 Drug Admin (SC/IM)
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49080 Paracentesis
36000 Periperal IV
94760 Pulse Oximetry
99000 Specimen Handling
36415 Venipuncture
V58.3 Suture Removal/Dx Change
36535 Venous Access Device (PICC)
86580 TB Skin Test

CAMO

CAMO

- Due to the sensitive nature of diseases seen in our clinic, have continued to book our own appointments:
  - CAMO facilitated name change so we are more easily found by them when booking
  - Maintains more confidentiality for patients
  - Ability to funnel new consults to fellows
  - Maintains flexibility for “urgent” nature of ID visits
  - We have not had problems scheduling appointments in past in timely manner
  - Have not refused consult since previous meeting

Current/Future Problem Areas
&
Support Requirements

Current/Future Problem Areas & Support Requirements

- Clinic Space
  - Sep 2004: move from 7D to 6B lost 7 offices & conf rm
  - July 2005: gain of 3 ID staff
  - Short: 2 offices
  - Only 4 exam rooms for 19 providers
    - 14 Physicians, 4 HIV research nurses, Public Health nurse
  - Need: 2 offices, 2 exam rooms
  - Solutions:
    - Maj Guillory is working with Space Cmte
    - We are considering clinic scheduling options

Current/Future Problem Areas & Support Requirements

- Decreased RVU per Provider
  - If same workload with more providers

  Solutions:
    - Public health had asked us to take over LTBI clinic, but we were understaffed for this – Now able!
    - Pulmonary clinic challenged with NTM clinic due to deployments and staffing – We can help!
    - Continue to maximize workload capture
      - Home IV therapy
      - Nurse clinic visits

Current/Future Problem Areas & Support Requirements

- Clinic Personnel
  - Significant increase in scheduling difficulty, patient check-in, and clinic procedures with more providers
    - Especially if no increase in exam rooms, but increased workload → extended clinic hours
    - Deployment of 4A in June ‘05 will compound problem
  - Solutions:
    - Cross-train secretary to help with clinic admin – in process
    - Consider changing position requirement for 4A to 4N to share procedures, check-in, and admin versus addition of 4N